DEPARTMENT OF THE ARMY
HEADQUARTERS, WALTER REED ARMY MEDICAL CENTER
6900 Georgia Avenue N.W.
Washington, DC 20307-5001

WRAMC Regulation
No. 40-106

6 May 2002

Medical Services

USE OF PHYSICAL RESTRAINT IN THE BEHAVIORAL HEALTH SETTING

1. History.
This regulation has been adapted from Walter Reed Army Medical Center Regulation 40-7dated 7 July 1999. This issue is the first printing of this publication.

2. Applicability.
a. Personnel. This regulation is applicable to personnel caring for patients in behavioral health clinical settings at Walter Reed Army Medical Center (WRAMC).

b. Circumstances. Patients will ONLY be restrained in emergent situations in order to limit their movement as a means to protect themselves and others, including staff, from harm.

3. Purpose.
This regulation provides guidance for the use of restraint in behavioral health care environments at WRAMC including building 6. This regulation ensures:

a. Restraint use in the Behavioral Health Care setting is limited to **emergent situations** in order to protect the patient from self-injury, as well as to protect all others from injury (including staff), resulting from an emotional or behavioral disorder. In contrast, the use of physical restraints in a medical-surgical environment is to support medical healing.

b. The appropriate, safe, and proper use of restraint in the delivery of patient care while advocating an environment free from restraint within WRAMC.

c. All staff understands the general principles governing the use of restraint, including guidelines for implementation and documentation.

d. The use of alternatives to restraint (non-physical interventions) is maximized in order to minimize the use of restraint. (See Appendix A).

e. All clinical staff recognize restraint use is a high-risk problem-prone procedure/process known to jeopardize the safety of patients served, and should be used *only* as a last resort.

4. References.

a. Comprehensive Accreditation Manual for Hospitals (CAMH), Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (current edition).

b. Restraint and Seclusion: Complying with Joint Commission Standards, Joint Commission on Accreditation of Healthcare Organizations (2002).

c. Restraint: Minimizing Use, Improving Outcomes in Acute Care Hospitals, Joint Commission Resources Tape Library (September 2001).

5. Explanation of Terms.

a. Restraint: Any method (chemical or physical) of restricting an individual's freedom of movement, physical activity, or normal access to his or her body.

b. Physical Restraint: Any method of physically restricting a person's freedom of movement, physical activity, or normal access to his or her body. Physical restraint may include the direct use of physical force, with or without a patient's permission, as a means of controlling physical activities to prevent the imminent risk of harming self or others. The physical force may be human, mechanical devices or a combination thereof.

c. Manual Restraint: Physically restraining a patient for a limited time and for a specific clinical (usually emergency) reason without the use of a mechanical device. Examples include keeping a confused patient from elopement by physically blocking him/her and physically holding a psychotic patient to administer medications.

d. Approved Physical Restraint Devices and Procedures:

(1) The WRAMC leadership and clinical staff have selected devices that are authorized to be used as physical restraints. However, it is imperative that each patient's care be evaluated on a case-by-case basis to consider and determine whether the implementation of such devices and procedures constitutes restraint.

(2) The ***only*** material or mechanical devices/procedures approved and currently available at WRAMC for physical restraint include: (from least to most restrictive).

(a) All 4 side-rails in the **up** position with seizure pads (*if intent is to restrain*).
(b) Therapeutic Holding in excess of 30 minutes.
(c) Mitts.
(d) Freedom Splints.
(e) Roll Belts.
(f) Soft Belts.
(g) Soft Limb Restraints (wrist/ankle).
(h) Sleeved Jackets.
(i) Non-Locking Cuffs .

(3) To provide for patient safety, no other products will be used as a physical restraint device under any circumstance. This includes, but is not limited to:

(a) The use of sheets as belts or tucked in so tightly as to restrict a patient's movement.
(b) Kerlex gauze used to wrap hands or as wrist restraint devices.
(c) The placement of tables in front of Geri-chairs to prevent patients from rising on their own.
(d) The placement of chairs so close to a wall or table as to prevent patients from moving or rising on their own.

e. Competent Registered Nurse(RN)/Staff: Staff members who have successfully completed hospital-approved restraint training which includes the safe application of physical restraint devices, release from restraint, monitoring procedures, and alternative non-physical treatment methods to the use of restraint devices. This training must be documented annually in the staff member's competency file.

f. One to One (1:1) Observation: 1:1 nursing care requires a staff member (RN, Licensed Practical Nurse, or technician) to be with the patient at all times and no further than an arm's length away. This is to ensure safety for patients whose level of functioning and/or behavior is significantly impaired to the

degree that they are a threat to themselves or others. An example of a patient requiring 1:1 nursing care is the patient placed in 4-point physical restraints.

g. Line of Sight (LOS) Observation: LOS nursing care requires a designated staff member to be no more than 10 feet away from the patient. The staff member must be able to see the patient at all times. This is to ensure patient safety and applies to patients whose level of functioning and/or behavior is impaired to the degree that they are felt to be at risk of harming themselves or others.

h. Emergent Situations: An instance in which there is an imminent risk of a patient harming himself/herself or others, when non-physical interventions are not viable; and safety issues require an immediate physical response.

i. Licensed Independent Provider (LIP):

(1) Any individual permitted by law and the organization to provide care and services without direction or supervision, within the scope of the individual's license and consistent with individually granted clinical responsibilities or privileges.

(2) A physician who has a state medical license.

(3) A resident who:

(a) Meets the state's requirement to practice medicine under the auspices of the training program.
(b) The resident has successfully completed the first year of post-graduate medical education.
(c) The graduate education program allows the resident to perform this activity.
(d) The activity is listed in the resident's job description.

(4) A physician without a state license is mandated to obtain a co-signature by a licensed independent provider within 24 hours of the initiation of restraint.

j. Show of Force: The assembling of a minimum of 5 personnel to present en masse to the patient to demonstrate that staff is capable of controlling the patient's behavior if he/she is unable to do so. This action helps in ensure a potentially hazardous struggle does not occur.

k. Episode of Restraint: A restraint episode is defined as the period of time covered by one restraint order (e.g., 4 hours for a behavioral health patients age 18 or over in restraints for medical-surgical reasons).

NOTE: The following are NOT considered physical restraints:

l. Forensic: Restrictive devices used by law enforcement personnel, e.g., handcuffs used for patients in police custody.

m. Medical Immobilization:

(1) The use of a device that is a customary part of medical, dental, diagnostic, or surgical procedures that immobilizes a patient or restricts a patient's access to part(s) of his or her body and is used to promote medical healing. Physical restraint differs from the use of medical immobilization mechanisms and practices. These procedures are considered a routine part of care and include (but are not limited to):

(a) Body restraint during surgery.
(b) Arm restraint during intravenous administration.
(c) Temporary physical restraint before administration of electroconvulsive therapy.

(2) The use of soft wrist restraints on an infant to prevent him or her from pulling or tugging on tubes and wires is included in this category. Infants and toddlers (age 0-36 months) lack the cognitive ability to be educated not to pull or remove lines and tubes.

n. Protective Devices: Mechanisms intended to compensate for a specific physical deficit or prevent a deviation from safety standards resulting in injury. These mechanisms usually include protective helmets, lap belts/boards (with release devices placed where the patient can access them), bumper pads and half bed rails. Protective devices may be used without a licensed independent provider order but require observation to identify or prevent untoward or undesirable effects.

o. Adaptive Support Devices: Devices intended to permit a patient maximum normal body function through the use of restrictive devices. The devices are used to meet the assessed needs of the patient who requires adaptive support (postural). Examples of adaptive devices include orthopedic appliances, braces, and torso support devices to maintain a sitting position and side rails used to help a patient self-turn.

p. Assistive Devices: A device used to enable a patient to perform normal activities of daily living independently such as eating, drinking, reading or self-positioning in bed. Examples of these devices include geri-chairs, over-the-bed tables, and side rails with controls.

q. Therapeutic Holding/Comforting of Children: Therapeutic holding or comforting of pediatric patients for 30 minutes or less, when its use is consistent with behavioral management standards. Note: **Therapeutic holding in excess of 30 minutes is considered to be a manual restraint.** This holding requires training which must be documented in the staff member's competency file.

r. Sedation: The use of pharmacological agents with a therapeutic intent that may result in the restriction of patient movement, normal activity, or body access.

s. Chemical Restraint: The use of pharmacological agents with no therapeutic intent as an alternative to physical restraint is termed chemical restraint. Chemical restraint is prohibited at WRAMC.

t. Seclusion: The involuntary confinement of a person in a locked room. This therapy is **NOT** authorized for use at WRAMC.

u. Time-out: Voluntary procedures used to assist individuals to regain emotional control by removing them from the immediate environment and allowing them to relax in a quiet area. A time-out exceeding 30 minutes is considered seclusion.

6. Responsibilities.

a. The Executive Committee of the Medical and Administrative Staff (ECMAS) supports initiatives created to encourage an organizational culture that emphasizes use of alternative measures to restraint and maximizes patient safety should restraints be required. The ECMAS supports the leadership philosophy that mandates:

(1) Initial and ongoing education, and training regarding alternatives to restraint, and the safe and proper application, monitoring, and use of physical restraints, to include criteria for device termination (See paragraph 8.g.). This includes nursing staff from all shifts as well as part-time, per diem, floats from other units and contract personnel; allied health students, physicians, therapists, mental health workers, and others who may need to be educated and evaluated on restraint policies and procedures. Because restraint is a high-risk and problem-prone procedure/process, annual competency assessment is warranted.

(2) Education and training to dispel myths associated with use of physical restraint. These **MYTHS** include:

(a) Restraint protects individuals from harm and prevents falls and serious injuries, particularly among the frail and elderly.
(b) Restraint use reduces liability risks.
(c) Restraint improves an individual's posture and body positioning.
(d) Restraint calms an agitated or confused individual and hence has therapeutic value.
(e) Fewer staff members are required when restraint is used. Hence restraint use lower staff costs.
(f) Staff feel more secure and comfortable when restraint is used.
(g) Effective alternatives to restraint do not exist.

(3) Maintaining a focus on patients' safety, rights, dignity, and well-being.

(4) Identifying and documenting clinical justifications for use of physical restraint.

(5) Providing patient and family education, as appropriate.

(6) Identifying and potentially preventing behaviors that lead to restraint use.

(7) Promoting preventive and alternative strategies that limit or eliminate the need for restraint.

(8) Ensuring that staffing levels and assignments in the organization minimize circumstances that give rise to the use of restraint and that they maximize safety when restraint is used. This includes the appropriate staffing level, mix, and scheduling to ensure safe patient care.

(9) Ensuring the integration of data collection and analysis into performance improvement activities because restraint use is a high-risk and problem-prone procedure. (See Section 11 of this policy for PI initiatives).

b. Department Chiefs.

(1) Clinical department Chiefs will ensure all clinical staff receive annual restraint education and training to ensure their competence if restraint use is or could be an interal part of their patient care. (Documentation of training will be maintained in the competency file for all non-privileged providers).

(2) Clinical department Chiefs will ensure that each service of their department, in collaboration with nursing personnel, determines the appropriate selection and number of devices to be stocked and available for the care of their patients (not all devices and sizes are appropriate for all care areas).

c. Logistics.

(1) Stock levels: The supply technician for each floor of the Medical Center will order and stock all appropriate physical restraint devices for patients receiving care on that floor (by specialty). All devices in all sizes need not be ordered and stocked on each floor.

(2) Laundering: Physical restraint devices are reusable except when otherwise indicated. Soiled devices will be turned in to Linen Management Branch with a completed DA Form 1974 (Laundry List, See Appendix C). Turn-around time for the laundering of restraint devices is approximately 48 hours. ***DO NOT place restraint devices in the regular laundry; they will be discarded.***

7. Requirements.

a. All restraint episodes must adhere to the following:

(1) Assessment, monitoring, application, management, and removal of restraints will be accomplished by staff who have completed competency-based education and training for the use of physical restraints.

(2) ***Restraints will only be used when alternative (less restrictive) techniques have failed, or when urgent clinical situations do not allow time to attempt them.*** See Appendix A, Alternative Strategies to the Use of Restraint.

(3) Patient rights, dignity, safety, and physical and emotional well-being will be preserved.

(4) Use of restraints will be based on an individual patient's assessed needs. Restraint use will be limited to emergency and clinically justified situations. Examples are delineated in the Appendix C.

(5) RNs or LIPs will determine the least restrictive method to manage individual patient behavioral problems. The least restrictive, safe and effective therapy/treatment appropriate to the patient's behavior will be used. See appendix B for an algorithm delineating the assessment process for unsafe behavior and when the use of restraints should occur.

(6) Decisions for the application and termination of restraints are limited to LIPs and RNs ONLY.

(7) The patient will be continuously monitored and reassessed by competent staff throughout all restraint episodes.

(8) The patient's physical and emotional needs will be met during all restraint use.

(9) The patient/family will be educated and involved in the decision process for the use of restraint when possible or appropriate. The patient will be informed of restraint discontinuation criteria. (See paragraph 8.g.).

(10) Care throughout all restraint episodes will be documented. Charting will delineate alternatives attempted, patient education provided, and the patient's response to treatment/therapy.

(11) Debriefing: Following each restraint episode, medical and nursing staff will debrief the patient and family (if appropriate). This session will be conducted as soon as possible, but no more than 24 hours following the restraint episode. Each session will assess the patient's knowledge and understanding of the role of restraints in his/her care. Each debriefing will be documented in the CIS **Debriefing Note**, found in the Psychiatric Environment Clinical Notes list.

8. Policies and Procedures.
The policies and procedures associated with use of restraint apply to each and every patient placed in restraint and to each episode of restraint use.

a. General. Restraints will be used only when alternative methods are not sufficient to prevent significant harm to the patient or others, or damage to/destruction of property. They may be used in response to emergent, dangerous behavior. The decision to restrain requires adequate and appropriate clinical justification. Restraints are to be applied for no longer than is clearly needed; any doubts about the need for restraints should be resolved in favor of an alternative to restraint. WRAMC does not permit the use of restraints for punishment, staff convenience, or in lieu of patient supervision. These standards do not apply to the use of law enforcement devices, e.g., handcuffs used for patients in police custody.

b. Patient Assessment.

(1) Risk Assessment: In order to plan effective alternative strategies to the use of restraints, all patients will be routinely assessed for behaviors that may be dangerous to self or others. A comprehensive assessment will include:

(a) Mental status examination to include, at a minimum, orientation, level of consciousness, suicidality, homicidality, and frank psychosis.
(b) Ability to understand and comply with treatment plan.
(c) Potential for drug or alcohol withdrawal.
(d) Drugs or illnesses that could alter mental status.
(e) Analysis of self-care deficits that could result in injury.
(f) Analysis of oxygenation, comfort, ability to rest, and environmental/milieu factors.

(2) Specific Criteria for the use of Restraints (**Clinical Justification**). Restraints will be authorized only when alternative strategies have proven ineffective or in an emergency situation, which threatens imminent danger and the patient demonstrates any of the following behaviors:

(a) Assaultive, combative, or destructive behavior.
(b) Attempts to harm self or others.
(c) Psychosis or other processes that produce serious and immediate risk of harm to self or others.
(d) Behavior so disruptive to the milieu that other patients' physical and emotional safety cannot be reasonably assured.

c. Preventive Strategies and Alternatives to Physical Restaint: Implementing the following actions and strategies may reduce or actually prevent the need for restraints:

(1) On admission, provide a thorough orientation including patient and family education regarding the nursing unit and the plan of care. Provide and discuss WRAMC Pam 40-93, When Restraints May be Needed: Considerations for Patients and Families (See Appendix E). In the nursing admission note or the physician history and physical, identify specific behaviors that may lead to the need for restraints and inquire on how the patient/family can contribute to the avoidance of restraint use during this hospitalization. Include normal strategies the patient utilizes outside the hospital environment to manage anger and stress.

(2) Increase frequency of nursing rounds.

(3) Move patients to a room close to the nurse's station.

(4) Limit visitors for therapeutic reasons as ordered by the physician.

(5) Decrease patient stimulation by:

(a) Changing the patient's immediate environment.
(b) Removing noxious stimuli.
(c) Offer a quiet room for the patient to relax.

(6) Provide verbal de-escalation or counseling with appropriate staff.

(7) Evaluate for possible medical conditions that may contribute to behavioral or cognitive deterioration.

(8) Evaluate patient's ability to perform Activities of Daily Living (ADL) in which limitations could affect mental or emotional status.

(9) Offer psychotropic medication (routine and prn) as indicated to decrease anxiety, psychosis, or agitation.

d. Choice of Restraint Method.

(1) Non-locking cuffs: A physical restraint device utilized to restrain each of the patient's 4 limbs providing immobilization and restriction of movement resulting in the patient's inability to cause harm to self or others. **Non-locking cuffs are the only approved physical restraint devices utilized in the Behavioral Health Care setting.**

(2) Manual: An approach without use of ancillary device in which a person physically limits a patients movement; used in emergencies to end a dangerous situation, redirect behavior, prevent elopement, or to assist in medication administration. This strategy may be used while awaiting arrival of restraint devices.

(3) Bedrails: All 4 side rails should be placed in the up position for any patient requiring restrictive/restraint devices. For safety reasons side rails are not standard equipment available in the Behavioral Health Care environment. They may not be available for use. One to One nursing observation will be utilized to ensure patient safety while restraints are employed.

e. Informed consent: Informed consent will not be obtained for the use of physical restraints in the behavioral health care environment. The use of restraints in behavioral health care settings is limited to emergencies. This precludes the opportunity to discuss and obtain consent without producing a potentially violent and dangerous situation. Education regarding the use of restraint devices, as part of the therapies employed in the clinical milieu, will be accomplished for all behavioral health patients during the admission process by providing them When Restraints May Be Needed: Considerations for Patients and families (WRAMC Pam 40-93). (Appendix E).

f. Guidelines for the Application of Restraints:

(1) LIP responsibilities:

(a) Conduct a **face-to-face assessment**.

(b) Order the use of physical restraints by initiating/ordering the CIS "**Restraint Orders Behavioral Health**" order set selecting the order set by the age of the patient (see subparagraph (d) below). All orders of the order set MUST be activated and are ordered by clicking the "assign all" key at the bottom of the CIS screen.

(c) Because physical restraints are used only in an emergency situation, a nurse may initiate their use. However, the LIP must be notified immediately of the restraint episode. The LIP must conduct a face-to-face assessment of the patient within **one hour** of the initiation of restraint. During this assessment, the LIP validates the clinical necessity for the continued use of the physical restraint and subsequently provides written orders within **one hour** of the initiation of restraints. **Verbal orders** and **telephonic orders** are acceptable if the physician cannot immediately report to the patient's bedside (but the face-to-face assessment must be done within 1-hour).

(d) Restraint orders must be time-limited. Limits in the behavioral health care setting are set at **four hours for patients age 18 and older.**

(e) The 6 orders are as follows (mandatory requirements):

(i) Place patient on 1:1 watch.
(ii) Delineate of the type of restraint device to be utilized.

(iii) Time-limited event: Each order for physical restraint must have a specific start and stop time.
(iv) Patient Education: Family involvement and notification when appropriate.
(v) Vital signs every 4 hours while in restraint.
(vi) Call the Psychiatrist on Duty for any changes in condition (not including discontinuation of restraint episode).

NOTE: **"PRN"** and **"continuous"** orders will ***NEVER*** be used.

(f) Continued use of restraints beyond the first 4 hours is authorized after conducting a reassessment by appropriately trained staff (RN or LIP). The LIP will provide an order, either written or telephonic, to continue the current therapy for an additional 4 hours. The physician ***MUST*** reassess the patient in person no less than every 8 hours for a patient. The interim face-to-face assessments may be conducted by a RN.

(g) Complete the **WR Restraint Note** in CIS documenting the **clinical justification** for the restraint episode, all **alternative measures attempted**, the **device to be employed**, and any patient or family **education** conducted.

(2) RN responsibilities:

(a) Conduct patient assessment to include vital signs, hygiene needs, and signs of injury.

(b) Ensure all preventive strategies and alternative measures have been exhausted.

(c) Initiate the use of a proper device.

(d) Notify and obtain an order (verbal or written) from the LIP within **one hour** of the restraint episode.

(e) Educate the patient and family, as appropriate.

(f) Conduct monitoring. It is essential to continuously assess and reassess the restrained patient to prevent harm and ensure the protection of patient's rights. The goal is to continuously validate the continued need for restraint and to ensure patient safety.

(g) Monitoring and assessment for all **4-point** restraint episodes will be conducted and documented (CIS protective device assessment screen) **every 15 minutes**; all other devices employed require monitoring and assessment every 2 hours. This assessment, appropriate to the type restraint employed, includes:

(i) Type of device and number of limbs restrained.
(ii) Restraint-associated injury.
(iii) Skin and circulation checks.
(iv) Behavior and current mental status.
(v) Orientation (alert and oriented X 1,2,3, & 4).
(vi) Readiness for restraint discontinuation.
(vii) Nutrition/hydration offered.
(viii) Release of devices and repositioning one limb at a time.
(ix) ROM/Skin care at device sites.
(x) Hygiene and elimination needs met.
(xi) The RN may terminate the use of restraint before the time limit of the physician order, when use is no longer clinically indicated (i.e., as soon as the patient's behavior is under control and the patient is able to cooperate with health care providers). Termination or an early trial of termination of restraint use is strongly encouraged.

g. Reapplication of Restraint within the original time limit: The RN may reapply restraints if indicated using the original order if the same behavior recurs within the original time limit of the order.

h. Transfer/Transport: When a patient in physical restraints is transferred/transported, the **devices will be removed** upon transfer of care (arrival at facility) to the receiving facility. An annotation of the aforementioned will be made in the transfer note. All devices will be returned to the sending unit or ward.

i. **Care of the Behavioral Health Care Patient in the Emergency Department (ED)**. Patients requiring restraints in the ED can be either Behavioral Health Care patients receiving care in a non-behavioral health care setting, or medical patients needing restraints for the safety of themselves or others. All patients will be considered medical-surgical until all medical reasons for the behavior have been ruled out. At this time, the Behavioral Health patient in the ED will receive care according to this regulation 40-7 B-H. For patients needing restraints as part of a medical therapeutic regimen, the ED will implement WRAMC Reg 40-7 (M-S). Documentation will be conducted on WRAMC OP 617/618 as appropriate.

9. Documentation.

a. LIPs will order restraints using the 6-Order Set found in CIS within 1 hour of initiation of restraints. Inpatient Psychiatric Restraint Orders, Care Flowsheet, and WRAMC Overprint 617 (See Appendix F) will be used when CIS is unavailable or in a setting without CIS where care is provided for behavioral health care patients (e.g. ED).

b. Initiation of restraints will be documented using the CIS "WR Restraint Note." Each physician order requires completion of a "WR Restraint Note." WRAMC Overprint 617, Inpatient Psychiatry Flow Sheet, will be used if CIS is unavailable.

c. Documentation in the Restraint Note must include the following, if applicable:

(1) **Circumstances** that led to restraint use;

(2) Consideration or failure of **non-physical interventions**;

(3) **Rationale** for the type of physical intervention selected;

(4) **Notification** of the patient's family, when appropriate;

(5) **Written orders** for use;

(6) **Behavioral criteria** for discontinuation of restraint.

(7) **Informing the individual** of behavioral criteria for discontinuation of restraint.

(8) **Each verbal order** received from a LIP.

(9) **Each face-to-face evaluation** and reevaluation of the patient;

(10) **15 minute assessments** of the patient's status;

(11) **Assistance provided** to the patient to help him/her meet behavioral criteria for discontinuation of restraint;

(12) **Continuous monitoring**;

(13) **Debriefing** the patient.

(14) **Injuries** sustained and treatment received for any injuries.

(15) Restraint-related death (Sentinel Event).

d. Ongoing monitoring will be documented in the Protective Device Assessment Screen or on the Overprint 617. Use of the Overprints is reserved for care in areas without CIS and during times when CIS is unavailable.

e. A debriefing session will be conducted and documented in the patient record following the restraint episode as delineated in paragraph 6-k on page 6 of this regulation. The note will include:

(1) Events leading to the restraint episode.

(2) Alternative measures attempted.

(3) Injuries sustained (by patient and/or staff).

(4) Documentation of the patient's/family's understanding of the events leading to the restraint episode.

(5) Actions to be taken to prevent future use of restraints.

(6) How the patient tolerated the procedure.

(7) Changes in the treatment plan.

10. Reporting.

a. The 24 Hour Nursing Report will include the name of each patient placed in restraints during that shift. If a patient was restrained more than once, the number of restraint episodes for that patient will be annotated.

b. The Night Supervisor will tally and report the total number of patients restrained in the past 24 hours.

c. Names of all behavioral health patients restrained requiring more than twice in a 12-hour period or restrained for 12 continuous hours will be reported to the Command on the 24 Hour Nursing Report.

11. Performance Improvement.

a. WRAMC's Performance Improvement (PI) Office will be responsible for implementing organizational policy for the use of restraint. The PI Office will evaluate the outcome of restraint use and report to the Quality Outcomes Committee (QOC) on a quarterly basis. Recommendation for action, based on the results of data analysis, will be determined by the members of the QOC. A summary report will be forwarded to the Governing Body at least annually.

b. Upon publication and implementation of this regulation, all episodes of restraint (100%) will be reported, documented (monitoring tool), and analyzed for a minimum of six (6) months. Collection of concurrent monitoring data and subsequent aggregation of the data will be conducted through WRAMC and Department of Nursing PI offices. Patient care unit staff will complete the daily monitoring of the restraint episode to (1) ensure patient safety, (2) ensure compliance with restraint policy and procedures, and (3) provide accurate data on each restraint episode to PI office.

c. Following the first report to the Governing Body following implementation of this policy, the Performance Improvement Office, in collaboration with the Governing Body, will determine if a more focused study and approach to the evaluation of restraint use is appropriate. Failure of the Governing Body to publish "in the absence of" changes to this regulation constitutes a continuance by the Governing Body of the regulation as delineated in paragraph (b) above.

d. The Chief, Nursing PI will oversee the design and implementation of a data-collection tool for the assessment and evaluation of each episode of restraint. The goal of the process is to understand why restraint is used so that interventions can be developed in order to reduce use, as appropriate. Data collection will include, but is not limited to the following:

(1) The length of time of each restraint use.

(2) Staff who initiated the process.

(3) The length of each episode.

(4) Date and time each episode was initiated.

(5) Day of the week each episode was initiated.

(6) Clinical justification and alternatives considered.

(7) Ordered by LIP (4 order set).

(8) The type of restraint used.

(9) Injuries sustained by the patient or staff during placement of the restraint device.

(10) Patient's age.

(11) Patient's gender.

(12) Patients unit or ward.

(13) Number of episodes.

e. Unit Managers, in collaboration with the medical director, are responsible for and will oversee the use of restraint on their respective units. Unit managers will ensure ongoing (concurrent) monitoring for compliance with policies and to assure patient safety. Intervention will be immediate to correct any variation from this regulation in all episodes of restraint use. Restraints will never be used in lieu of adequate and appropriate staffing.

f.. To ensure thorough and accurate data collection, each episode of restraint requires the completion of a **WRAMC Form 1811**, Report of Unusual Occurrence. This form will be completed at the time each order is written and immediately forwarded to the Risk Management office.

g. All episodes of restraint will be documented on the 24 Hour Nursing Report (total number of restraint episodes every 24 hours). The total number of restraint episodes for each patient will be tracked throughout his/her hospitalization. Names of patients restrained more than twice within 12 hours, and those restrained for 12 continuous hours will be reported to the leadership.

12. Education.

a. Clinical Departments Chiefs will ensure all appropriate personnel receive initial training during orientation and ongoing education and training annually on all aspects of the use of restraint (alternatives, clinical justification, application, monitoring, and termination) as appropriate.

b. Competency training for Department of Nursing personnel will follow orientation (initial education) and occur on the individual nursing units.

c. Training on appropriate actions during emergent situations (including notifying nursing and medical staff will be provided to non-clinical staff.

APPENDIX A
Alternative Strategies to the Use of Restraint.

Seven broad categories of alternatives to restraint use are categorized below to provide some specific options to care providers. Remember, when any of these or other alternatives do not work, choose the ***least restrictive restraint*** possible.

1. **Providing Companionship and Supervision**:
    a. Ask family, friends, or volunteers to stay with the patient
    b. Determine when the patient needs one-to-one attention (typically at night) and intervene accordingly

2. **Changing or Eliminating Bothersome Treatments**:
    a. Initiate oral (as opposed to IV or NG) feedings, when possible
    b. Remove catheters and drains as soon as possible
    c. Have the patient wear underwear over the Foley catheter

3. **Modifying the Environment**:
    a. Increase or decrease the amount of light in the room, depending on glare and the patient's preference or needs
    b. Make water more accessible
    c. Position the bedside commode so that the patient can use it easily
    d. Place the urinal within reach
    e. Arrange for patient to be near the nurse's station, unless the stimulation triggers agitation or worsens confusion
    f. Leave the side rails down if the patient tends to climb over them, or use half rails to prevent his/her rolling out of bed
    g. Reduce environmental noise
    h. Keep the call button accessible
    i. Use lap cover over legs while patient is in chair
    j. Place an exercise mat by the bed for patients' with a tendency to fall
    k. Place non-skid mat by the bed for unsteady ambulating patients
    l. Provide items that occupy the patient's hands

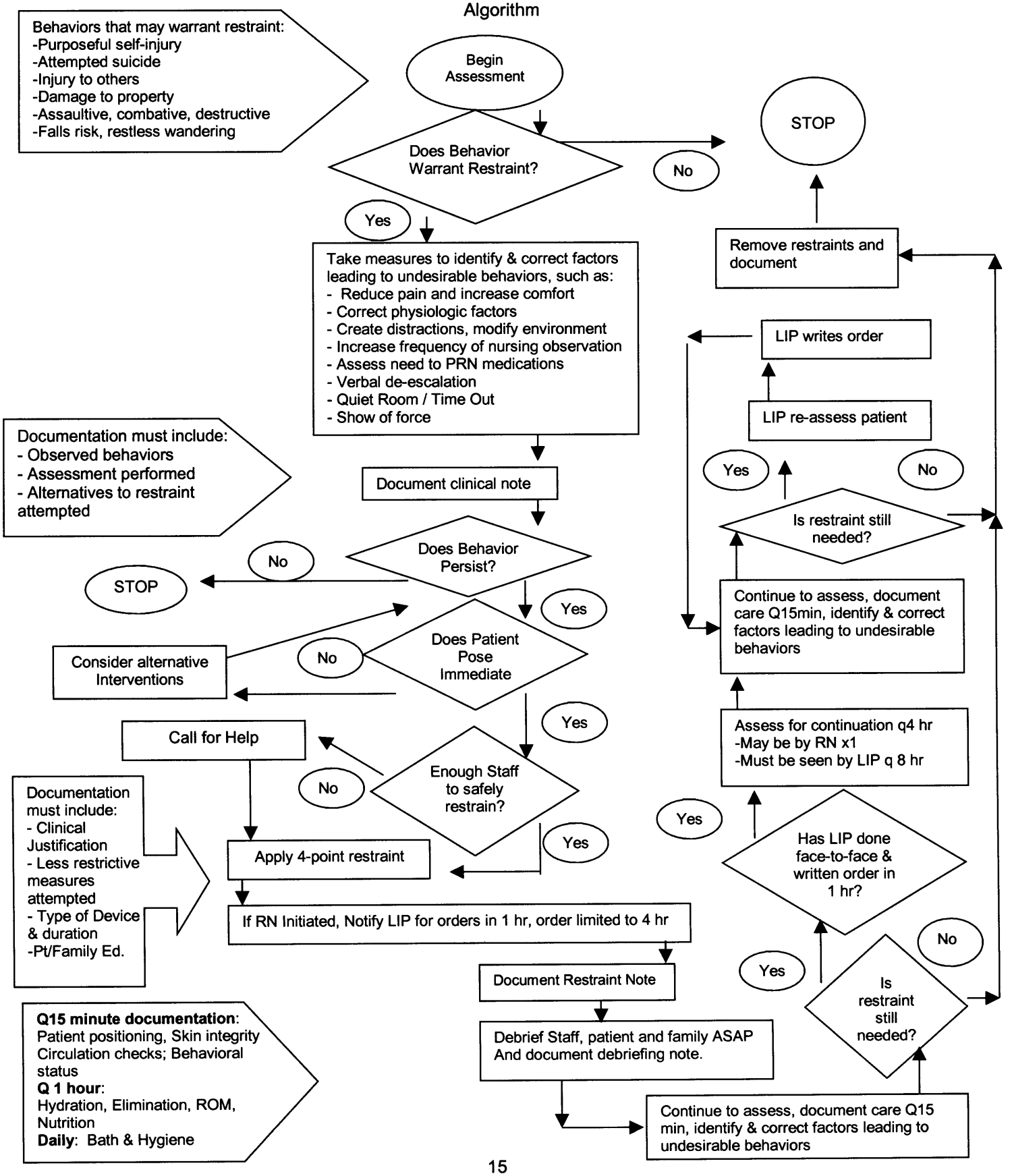
4. **Reality Orientation and Psychosocial Interventions**:
    a. Involve the patient in conversation. Don't talk over him/her.
    b. Explain procedures to reduce anxiety and fear and convey a sense of calm
    c. Provide reality links when appropriate (TV, radio, calendar, items from home)
    d. Use active listening to elicit the patient's feelings

5. **Providing Food**:
    a. Some patients become restless, particularly at night, because their blood sugar level drops. Providing them with a half of a sandwich and a glass of milk (if on diet) often relieves the restlessness.
    b. Provide appropriate snacks for time of day (not cereal when awakened at night, as this may be perceived as "breakfast")

6. **Offering Diversionary and Physical Activities**
    a. Use TV, radio, or music for diversion (depending on the patient's cognitive capacity and individual preferences)
    b. Enlist the aid of an Occupational or Physical Therapist/Technician
    c. Provide exercise or ambulation whenever possible
    d. Initiate training in activities of daily living
    e. Use Physical or Occupational Therapists or Technicians to help the patient increase his/her strength and endurance and feel a sense of accomplishment

7. **Designing Creative Alternatives**:
    a. Use music chosen for the patient to reduce agitation or to provide diversion
    b. Develop toileting routines to facilitate elimination and reduce falls related to elimination
    c. Consult with other disciplines (Psychiatry/Psychology) about appropriate behavioral interventions

APPENDIX B
Algorithm



APPENDIX C
DA Form 1974 (Laundry List)

LAUNDRY LIST
(MEDICAL TREATMENT FACILITY AND ORGANIZATION)
For use of this form, see AR 210-130; the proponent agency is DCSLOG

DATE

FROM *(Organization)* | TEL EXT | TOTAL PIECES

QTY	ARTICLE	QTY	ARTICLE
	Apron		Napkin
	Bag, barrack or duffel		Pad, Bed
	Bag, laundry		Pants, pajama
	Bag, sleeping		Pantsuit, top
	Bathrobe, adult		Pantsuit, bottom
	Bathrobe, infant		Pillow
	Blanket, cotton		Pillowcase
	Blanket, crib		Parka
	Blanket, wool		Rag, (lb)
	Cap, food handler		Sheet, bed
	Cap, field		Sheet, fitted
	Case, bag, sleeping		Shirt, scrub, OR
	Cloth, wash		Shirt, sweat
	Coat, convalescent		Shirt, wool
	Coat, food handler		Shirt, utility
	Coat, pajama		Shoes, canvas
	Coat, operating		Shoes, athletic
	Coveralls		Smock, physician
	Cover, mattress		Socks, (pr)
	Cover, mayo		Spread, bed
	Cover, helmet		Tablecloth, lg
	Curtains, shower		Tablecloth, sm
	Drapes (sq. yd.)		Towel, bath
	Drapes, tie (pr)		Towel, hand
	Drawers		Trousers, field
	Dress, hospital, white		Trousers, food handler
	Gloves, (pr)		Trousers, OR, green
	Gown, operating		Trousers, sweat
	Garment, surgical		Trousers, poly, wh
	Hood		Trousers, utility
	Jacket, field		Uniform, nurse
	Liner, jacket		Undershirt
	Mat, bath		Wrapper
	Mop		

FOR THE LAUNDRY	FOR THE ORGANIZATION
SIGNATURE *(Receiver)*	SIGNATURE *(Delivered by)*
SIGNATURE *(Shipper)*	SIGNATURE *(Pickup by)*

DA FORM 1974, JUN 86 — EDITION OF OCT 79 IS OBSOLETE — USAPPC V2.00

APPENDIX D
Examples of Indications for Restraint.

Listed below are some specific examples of clinical indications for the use of least restrictive time-limited restraint at WRAMC. Examples of behaviors justifying a Restraint Order (but not limited to):

1. A patient is throwing objects at another person.

2. A patient is striking medical personnel, other patients, or visitors .

3. A patient is being prevented from injuring self (removing dressings, pulling at tubes/catheters, or injuring themselves in other ways).

4. A patient is confused and cannot be oriented to environment (wandering with potential for injury).

5. A patient is forgetful (may get out of bed unattended with resulting injury).

6. A patient has a medical condition that affects cognitive level (e.g. electrolyte imbalance, altered oxygen levels, diabetic crisis, decreased cardiac output).

7. A patient has medication-induced psychosis.

8. A patient is withdrawing from a substance (e.g., alcohol, benzodiazepines).

9. A patient has dementia or organic brain syndrome with agitation.

10. A patient is destroying property.

11. A patient exhibits purposeful self-injury such as self-mutilation or attempted suicide.

12. A patient has hyperactivity resulting in physical exhaustion.

13. A patient is under the influence of a substance (e.g., alcohol) and uncooperative.

APPENDIX E
WRAMC Pam 40-93 Restraint Brochure (Trifold)

You need to know...

When the decision to use a restraint is being considered (or must be made in case of an emergency), the staff will make every effort to inform you as soon as possible in order to discuss the reasons, the alternatives considered, and to seek other possible strategies with you to help keep the patient as safe and comfortable as possible.

We encourage ongoing discussions of your concerns. Please feel free to consult with the doctor or nurse caring for you-family member if you have concerns or questions.

The Patient Representative is also available by calling

202.782.6866

Walter Reed Army Medical Center is committed to providing comprehensive healthcare with a caring, competent staff. We respect our patients, recognize their personal preferences and values, and strive to protect their dignity.

The proponent agency of this pamphlet is the Walter Reed Army Medical Center Performance Improvement Office. Users are invited to send suggestions and comments on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, WRAMC, ATTN: Performance Improvement Office, MCHL-N Washington, DC 20307-5001

FOR THE COMMANDER:

OFFICIAL: JAMES R. GREENWOOD
COL, MS
Deputy Commander for Administration

ERIK J. GLOVER
MAJ, MS
Executive Officer

DISTRIBUTION:
F

Walter Reed Army Medical Center

WRAMC Pam 40-93

01 June 2002

Walter Reed Army Medical Center

When Restraints may Be Needed in the Health Care Setting

6900 G
W

WRAMC Pam 40-93

Alternatives to restraints...

It is the goal of Walter Reed Army Medical Center to provide all patients with a safe hospitalization experience. The staff are committed to protecting the rights, dignity and safety of each patient.

You may be wondering...

Patients who have been alert and oriented at home may become confused and unable to cooperate with their care and treatment while in the hospital. This change may be caused by medical or psychiatric illness, surgical procedures, unfamiliar surroundings, a change in daily routine or sleep patterns, or medication.

Occasionally, the result is behavior which poses serious risk to the person's safety or that of others in the immediate environment.

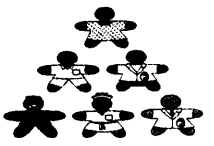
The care givers are competent to manage these temporary situations on a regular basis. Staff members may need only to provide reassurances or explanations, closer observation, diversional activities, counseling, quiet time, or attention to needs for comfort and rest. In more serious situations, changes in medications, treatment or the use of special equipment such as mitts may be necessary to keep the patient safe.

How friends and family can help...

Often the support of a familiar person can be beneficial in calming an anxious or confused person, and helping the patient to rest, recuperate and regain a normal state of health and functioning. Also, the knowledge and availability of loved ones can be an important resource to the health care team in maintaining safety. The staff members may talk about the possibilities of family or friends:

* Spending extra time with the patient on the telephone or during visiting hours when possible.
* Offering suggestions for continuing safety and comfort.
* Helping patients understand their condition, situation and the need for compliance with treatment.

Please discuss your ideas and suggestions with the nurses.



If alternatives are not satisfactory...

In some cases, the alternatives discussed above are not sufficient to keep the patient or others around them safe. If the behavior demonstrates significant danger of the patient harming him/herself, someone else, or seriously interfering with his/her treatment (e.g., pulling at tubes or lines which could result in serious injury if removed) a restraining device may be needed to maintain safety.

These devices may include belts, jackets, soft wrist restraints or four point non locking cuffs. In all cases, the least restrictive device possible will be used. You should also know that these devices may only be used with the advice and approval of the physician.

During the period when such devices are in use, staff members will continually reassess their necessity and discontinue or change to a less restrictive method as soon as possible.

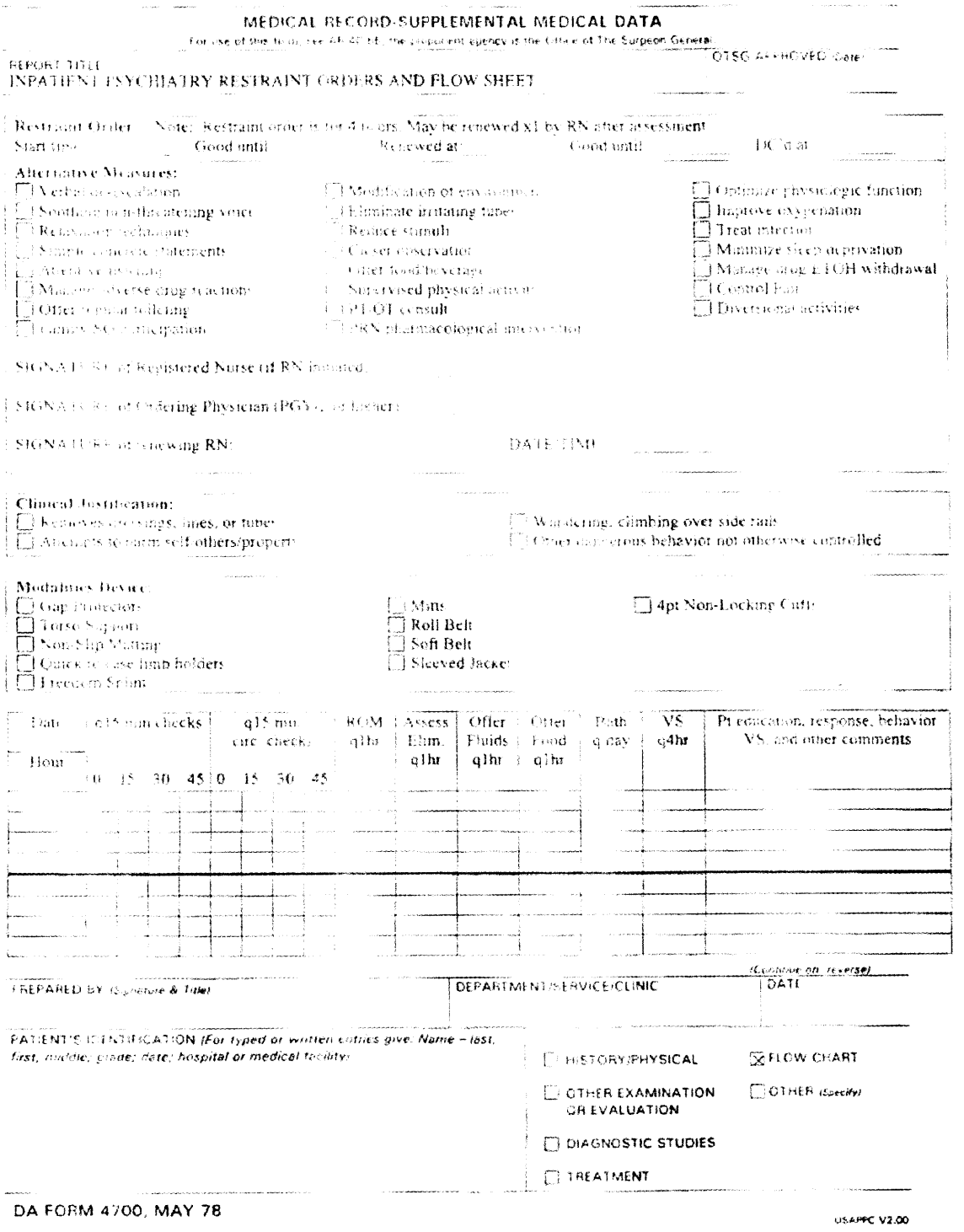
Special Care will be given...

While a person requires restraints, the nursing staff recognizes that they have special responsibilities to provide care, comfort, emotional support and attention to such needs as fluids, nourishment, use of the toilet or bedpan, and changes in position. An individual in restraints is observed very closely by the staff. The person's needs are attended to with concern for their comfort, privacy and dignity.

Walter Reed Army Medical Center

APPENDIX F

SF OP 617: Inpatient Psychiatry Orders and Flowsheet



MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

REPORT TITLE

INPATIENT PSYCHIATRY RESTRAINT ORDERS AND FLOW SHEET

Restraint Order Note: Restraint order is for 4 hours. May be renewed x1 by RN after assessment

Start time Good until Renewed at Good until DC'd at

Alternative Measures:

- Verbal de-escalation
- Soothing to non-threatening voice
- Relaxation techniques
- Simple concrete statements
- Allow venting
- Monitor adverse drug reactions
- Offer regular toileting
- Continue ADL participation
- Modification of environment
- Eliminate irritating tubes
- Reduce stimuli
- Closer observation
- Offer food/beverages
- Supervised physical activity
- OT/OT consult
- PRN pharmacological intervention
- Optimize physiologic function
- Improve oxygenation
- Treat infection
- Minimize sleep deprivation
- Manage drug/ETOH withdrawal
- Control Pain
- Diversional activities

SIGNATURE of Registered Nurse or RN initiated

SIGNATURE of Ordering Physician (PGY-, if applicable)

SIGNATURE of renewing RN: DATE/TIME

Clinical Justification:

- Removes dressings, lines, or tubes
- Attempts to harm self/others/property
- Wandering, climbing over side rails
- Other dangerous behavior not otherwise controlled

Modalities/Device:

- Gap Protectors
- Torso Support
- Non-Slip Matting
- Quick release limb holders
- Freedom Strips
- Mitts
- Roll Belt
- Soft Belt
- Sleeved Jacket
- 4pt Non-Locking Cuffs

Date / Hour	q15 min checks 00 15 30 45	q15 min care checks 0 15 30 45	ROM q1hr	Assess Elim. q1hr	Offer Fluids q1hr	Offer Food q1hr	Bath q day	VS q4hr	Precipitation, response, behavior VS, and other comments

(Continue on reverse)

PREPARED BY (Signature & Title) DEPARTMENT/SERVICE/CLINIC DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

- ☐ HISTORY/PHYSICAL
- ☒ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIAGNOSTIC STUDIES
- ☐ TREATMENT

DA FORM 4700, MAY 78 USAPPC V2.00

APPENDIX G
Behavioral Health Restraint Debriefing Note

1. Who was present [pick list MD, RN, Tech, other, and list # of each:].

2. Was patient/family interviewed and assessed for understanding of this incident:
   - ☐ Yes
   - ☐ No. If no: [Free text with explanation]

3. a. What led to the incident: [Pick list to include:]
   - · Removes dressing, lines, tubes
   - · Wandering, climbing over side rails
   - · Attempts to harm self, others, property
   - · Threatening speech or behavior
   - · Other, specify: [Free text]

   b. Alternative measures taken to avoid restraints: [Pick List]
   - · Verbal counseling/de-escalation
   - · Offer quiet room/time
   - · Offer PRN medications
   - · Remove from negative stimuli
   - · Change in behavioral status
   - · Show of force
   - · Other, specify: [Free text]

   c. Restraint episode resulted in physical injury to
   - ☐ Staff [Free text to describe/delineate injuries]
   - ☐ Patient [Free text to delineate/describe injuries]

4. Actions taken to protect the patient's privacy/confidentiality [Pick List. Choose as many as apply].
   - · Patient redirected to private room
   - · Other patients and visitors removed from the area
   - · Chart access limited to ward area
   - · Patient covered during movement
   - · Patient moved through lease congested area
   - · Other. Specify [Free text]

5. In dialogue with patient following/during incident:
   - • Does the patient understand events leading to incident? [Free Text]
   - • How did the patient tolerate restraint episode? [Free Text]

6. Does treatment plan need modification?
   - ☐ No
   - ☐ Yes. [Free text for "how" modified]

The proponent agency of this publication is the Directorate, Performance Improvement/Risk Management Office. Users are invited to send suggestions and comments on DA Form 2028 (Recommended Changes to Publications and Blank Forms) to Commander, Walter Reed Army Medical Center, ATTN: MCHL-MAO-PI, 6900 Georgia Avenue N.W., Washington DC 20307-5001

FOR THE COMMANDER:

OFFICIAL:

ERIK J. GLOVER
MAJ, MS
Executive Officer

JAMES R. GREENWOOD
COL, MS
Deputy Commander for
Administration

DISTRIBUTION:
F